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MEMOIRS OF A MEDICAL ENGLISH TEACHER

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Abstract

For any university teacher grappling with the challenge of initiating an ESP (English for Special Purposes) course in an EFL situation, some very important questions must be dealt with, and the sooner the better, to ensure the success of the program of study. This paper focuses on English for Medical Purposes, but the same considerations would arise for English related to law, business, etc. Following are some of the main questions demanding attention: 1) As the instructor, what are my expectations of the students? Has any previous standard for learning been set by my university? 2) Have I investigated my prospective students' language and interest level sufficiently to determine if my expectations are realistic or not? What are they really ready for? What is the next logical step in their language development? 3) Have my students formed any expressible expectations for the ESP study? 4) Are my objectives in keeping with the students' age and interests, academic level, student readiness, acquired knowledge (in terms of both subject matter and target language), and the time available for the course? 5) Which language skills should be emphasized? In which skills are the students most deficient? Which skills will be called into use in the future of their profession? Which skills will be of most benefit to all the students in the future? Will all of them use English professionally? 6) What are my choices for textbook selection? Will I feel adequate to the task and be able to prepare for the class and use the textbook confidently? 7) What kinds of classroom activities and methods of testing will best compliment my objectives? How can I best evaluate the amount of progress being made by the students? 8) How much can be attempted and actually achieved in a 15-week course? A year-long course?

**The above questions are noted when they are the focus of discussion in the various segments of the text of this paper.

Key Words: ESP (English for Special Purposes), expectations, standard, student readiness, skills, methods.

Introduction

This is being written on the assumption that there are a significant number of educators in EFL teaching situations in medical universities (in Japan and other countries as well) who think forging ahead toward fluency in English will benefit the doctors of tomorrow, their patients, and the future of medicine worldwide. Yet, however noble the vision may be, there are countless impediments to the goal. When trying to build a sound syllabus for even one medical English course, numerous hurdles should be expected. The considerations discussed in this paper are some of the most pressing issues that made themselves obvious during a semester-long medical English course which I taught and continued to develop over a period of more than six years. Some of the challenges were surmountable, and hopefully the insights and trial-and-error conclusions that are presented here will be of help to those involved in teaching medical English or other ESP courses. Some may be fortunate enough to have the luxury of a year-long curriculum, but most of the matters discussed here are from the perspective of what might be a successful undertaking for a one-semester course that meets once a week for 90 minutes.

Teacher Expectations

The teacher's expectations will predominate in this paper, because no curriculum existed and no standard had been set by myself or the medical school when I began teaching the ESP course. Therefore, all of my teaching over the period of seven years was very experimental and a constant reevaluation of my assumptions. Eventually, I was able to arrive at objectives and standards which I could believe were doable, beneficial, and would make the best use of the limited time available for concentrated medical English study. Following are some of the expectations (as they stood when I began the course) that most influenced my total plan for teaching; after each one, there will be a short discussion about how that expectation withstood the test of time, as well as how objectives evolved and grew out of it:

Expectation #1) (***Motivation***) Medical students in the EFL setting will be highly motivated and ready to accept the challenge of even an intensive study of English in their field of interest.

Discussion: **(Relates mainly to questions 1, 2, and 3 in the Abstract)**

Through my own experience, I tend toward the conclusion that first and second year students may or may not have any instant, special motivation for learning medically related things, but they usually have a little. Besides that, judging from the number of students who successfully completed two years of general, voluntary conversation classes here at FMU, only a relatively small percentage of students will have a particularly deep interest in English in general. About 35% completed conversation classes for one year, but no more than 15% completed all four courses offered during their freshman and sophomore years. Conjecturing, we might imagine that the number of general education students who, from the onset, have both a deep interest in learning difficult medical things and a committed enthusiasm for learning English is probably lower than we teachers would hope for.

One can't help wondering how much background knowledge and medical interest the students really have when they enter the medical school, but there is danger in being too impatient After all, for many in the medical course, it may have been their parents' decision for them to persue medicine. Even such students may eventually becoming highly motivated as their interest is sparked and captured by various points of study along the way. Dynamism grows as skill and confidence grows. After one particularly lacklustre class which I had tried especially hard to make stimulating, I came to ask myself the question, "Just how dynamic would even a fifth-year medical student be if he suddenly found himself in the operating room being asked to perform a delicate neurosurgery?" Success with all skills comes in small steps, and confidence and motivation is likely to follow in corresponding, small measures, too. The motivation factor can hardly be separated from the point that is discussed next.

Expectation #2) **(Language Development)** **(Student Readiness)** With at least six years of prior English study, Japanese college-level students (especially those who have managed to pass the difficult entrance exam of a medical university and surely have quite a deep interest in medicine) will have a strong, basic foundational vocabulary and biological knowledge which will make it possible to dive into the challenge of a more technical study.

Discussion: **(Especially relating to questions 2, 3, 4, and 7 in the Abstract)**

The notion of student readiness is only valid if a realistic standard has already been established. Of course, from the beginning I insisted that my students rise to the challenge of achieving the objectives I had set, but this hardly means that I could fairly judge what they were really ready for and prepared to learn. Oddly enough, at the onset, I actually

thought I could predict "where they would be" in each language skill, but time proved me wrong. I was projecting based on past experiences with other (non-medical) classes. I especially recalled former situations when I had been teaching in an intensive ESL program for foreign students at Iowa State University in the U.S. I could remember conversations with incoming students, many of whom were Japanese. We often talked about their ailments and other things related to their bodies. Based on these impressions, I had unconsciously formed expectations of what I thought my freshmen Japanese students in the EFL setting would be able to do. How far off I was! Why such a big discrepancy? Had there been something wrong with the English courses that the Japanese students had taken during junior high and high school? Why wouldn't they know words as "simple" as those for the signs of a common cold?! It is so easy to say that students should already know these things and to criticize their former study, but in reality, I believe the inability to talk about various parts of the body or the ideas associated with many everyday maladies was due to their having no necessity or opportunity to be actively involved in such conversations or even readings. What chance had they had to concentrate in detail on the category of vocabulary related to health and medicine? On the other hand, ESL students immersed in an English culture soon learn names of body parts and words for illnesses and symptoms, etc. They learn these rapidly in many and varied situations, for example, when getting their hair cut or styled, buying clothes and shoes, filling out health and insurance forms for school, helping a sick roommate, visiting a clinic--the opportunities are endless. EFL learners lack such situations of active involvement where language is accumulated rapidly and deeply. I must admit that I was very frustrated with my first medical English class, but my impatience was quite unfair. The students had not had opportunities to achieve the kind of readiness that I was demanding of them. This was to be their first real chance to do so, and this fact took time to be realized and appreciated. The truth of the matter was that I had little or no understanding of the level of their medical knowledge in their native language, let alone the target language.

After all, there is no sense in trying to teach logarithms and calculus to a student who has not yet mastered adding and subtracting. Unfortunately, this was the kind of situation I found myself in after the first couple months of teaching the course. To get some idea of your students' acquired knowledge in both the subject area (medicine, law, etc.) and the target language, pretesting is essential. And interviewing even a few students will prove enlightening. Pretesting and interviewing are highly recommended, because they may help to avoid a long period of trial and error, which can be as discouraging for the students as it is

for the teacher. These two simple procedures, however, may or may not be so useful for finding out students' expectations, but can help immensely for selecting teaching materials, methods, and for getting feedback on what has already been tried. A pretest need not be long or intricate but should contain basic notions which cannot be further simplified. Such a test follows:

Directions: All of the words below are symptoms of the common cold. For each blank, you will try to write one English word, paying attention to spelling. Hints are given.

r _____	n _____	na _____	di _____
s _____	th _____	fe _____	v _____
stiff m _____		co _____	ch _____
night sw _____		h _____	sn _____
loss of a _____		fa _____	

Answers: runny nose, sore throat, stiff muscles, night sweats, loss of appetite, nausea, fever, cough(ing), headache, fatigue, diarrhea, vomiting, chills, sneezing (sneeze).

Average Scores for 298 second year students: On Pretest: 29.7% On Final Exam: 89.5%

Of course, there are several options for formatting the pretest to control the difficulty and target different skills. As illustrated above, one might give clues only in English, making the task quite severe even though only "common" terms are being asked for. A kinder approach would be to first provide the Japanese for the English word being sought. Even kinder would be to give first letter clues, or even first and second, or even first and last letter clues. The easiest might be to present the English words and ask them for the corresponding Japanese term, but this method only tests word and meaning recognition. Such translation tests do not ascertain whether or not the target English terms have actually been internalized. A totally different approach is to use dictation. Although the level of difficulty increases dramatically, it need not be so intimidating. Dictation as a method for teaching and testing is discussed in more detail later in the paper.

In summary, pretesting and interviewing can aid considerably with total planning and help to ward off frustration and impatience for both the teacher and the students. One cannot escape the fact that in the art of medicine, much learning must be sequential. What's more, interest and confidence only come with readiness. Personal observation, several years of pretesting, and some recent research bear out the fact that entry-level students do not possess a "working" knowledge of even the most basic medical English vocabulary. In research carried out primarily in medical schools (Tamamaki and Fujieda, 1998), both medical and nursing students were tested to investigate vocabulary development for medically related things. A 40-item written test was given (20 English terms to be translated into Japanese and 20 Japanese words to be put into English), involving general medical words for treatment, diagnosis, materials, disease names, symptoms, etc. The average score for the first-year medical students was about 57%. For second year students, the average score was about 10% greater. First and second year nursing students came in with a combined average of just over 40%. Some of the pretests that I used produced even lower average scores, because the prompts were given only for the first letter or first two letters of the English word (as the one above). One simple pretest that I used for four years was for all visible body parts; students were asked to write the English word as the teacher pointed to each part. This pretest was repeated for 3 years with classes of 100 medical students each. The average score was 38%, with the average of each class varying only by 3 points. This test included easy items such as ear, eye, chest, shoulder, arm, etc., but also included more challenging parts like the hips, buttocks, ankle, wrist, thumb, toes, elbow, chin, etc. The average percentile can vary greatly, depending on the difficulty of the items, the number of prompts or clues, and of course, the English skills involved. Dictation is another satisfactory method when pretesting for very basic terms. By using such words in short sentences which would be natural in the hospital setting, an instructor can get a better idea of students' listening skills. Unfortunately, it is not especially reliable for determining the overall level of vocabulary development, because some students who might have very high word recognition when reading may have almost no ability of word recognition when listening. However, another plus of dictation is that it can be diagnostic for spelling and grammatical knowledge. Even though it may have limited usefulness for pretesting, it should not be discounted completely. Such a pretest may be very necessary if dictation is to be used as a teaching tool throughout the course, and the teacher hopes to measure the amount of progress made by the end of the semester.

Expectation #3) (***Selection of Teaching Materials***) By previewing several of the most popular medical English textbooks being currently used in Japan, I should be able to get an idea of what is commonly expected of medical students in their first two years of college. This will be a reliable guide for determining their academic level and the subject matter that will suit my students' interest level and capabilities.

Discussion: (**Mostly question 6 of the Abstract is considered here**)

The kinds and levels of medical English textbooks are as varied as the weather here in Fukui Prefecture. In this kind of course, the danger of choosing an overly simple textbook and thereby insulting the intelligence of the students is slim. It is more likely that we teachers are prone to select what we deem as an attractive text (without getting any student input) and then demand that students rise to the challenge of it. In fact, it was a very simple thing to ask about five to ten students of varying abilities to come separately to my office to look over three textbooks (and approaches) that I was considering. I asked each to read very short passages from the choices and had them peruse the contents. They were able to offer fairly firm opinions which, by the way, did not usually coincide with mine. Unfortunately, I did not start this practice until my fourth time to teach the course. Without a doubt, it made the classes more successful. During the last two years of teaching the class, I also did this with supplemental materials I was intending to use in the class. A concensus is not always possible, but which topics hold more student interest will become apparent.

In all fairness and wisdom, part of the textbook selection has to be based on the special interests of the teacher. Using materials that really fit the teacher's strengths is important. Students have a sixth sense when it comes to discerning any insecurity on the part of the teacher, and I may even add that they can sense it no matter how hard a teacher may try to cover it up. Judging from student feedback, the most successful medical English courses were the last two that I taught, in which I chose to focus on a special love of mine--preventive medicine. This also included notions of holistic medicine as compared to surgical and drug therapies. Approximately 25% of the reading and lecture focused on what medical personnel can do to help people stay well, as opposed to the overriding tendency of many doctors today who concentrate more on just "fixing" the body after it "breaks". After all, a teacher's enthusiasm is a large factor in creating student motivation. What's more, regardless of the approach you decide to take with subject matter, the same essential medical vocabulary will appear and you still have the option of controlling the level of technicality in the language.

Perhaps my biggest breakthrough came after the second year that I was teaching the medical English course. Because students took the course for only one semester during their second year of general education classes, I had felt from the beginning that it should be intensive, so as the core of the content, I chose "authentic" medical research reports that I hoped would become the basis for vocabulary acquisition, reading practice, writing practice, discussion, etc. The results were far from what I had hoped for. Even though I had carefully selected journal articles that dealt with basic medical problems and involved almost all body systems, I (and I'm sure the students as well) felt that we were wading through thick mud. One day on a routine vocabulary quiz, most of the students were not able to remember the terms digits and phalanges which are related to parts of the hands and feet. So I asked students, one after another, "Well then, in common English, what do you call those five things at the ends of your feet?" but I was surprised to find that almost no one in the class of 50 students could tell me. The few who had some vague idea were only able to pronounce the word toes as "twos", so their knowledge was not of much use to them either. Instructions like "point to your belly button" or "show me your thumb" had similar results. Finally, it dawned on me that I was expecting them to learn "dyspnea" before they could fully understand and say "shortness of breath". From then on, I started teaching all of the common terms along with the technical ones, but needless to say, it became an almost mind-boggling exercise in vocabulary study alone. It became clearer and clearer that they were not ready for what I wanted them to do and that what they were studying was not becoming usable English, in the broadest sense. Without really studying and practicing natural collocations of even the common terms, speaking and listening skills could not improve. Although they made progress in terms of reading, I was not satisfied with the outcome. In what was intended to be an integrated skills class, production skills soon took a back seat. What went wrong? My expectations had not been realistic in terms of the time constraints; we had only 15 classes and that included the midterm testing period. Once a week for just an hour and a half is not much time. Above all else, the larger problem was that I had not adequately investigated my students level of learning and what would be the next logical and doable step in their journey toward English fluency in medical and social situations.
**(See discussion of expectation #4 below for discussion of specific textbooks.)

Expectation #4) (***Focus on Skills***) (***Activities and Methods***) Focusing on reading, but integrating all of the other language skills will make the course more interesting and the English more useable.

(This discussion relates mainly to questions 1 and 4 - 8)

In fact, including some speaking, listening, and writing did make the study more interesting. Teaching the course for the first time, I focused on technical medical journal reports from Medically Speaking (P.L. Sandler, 1982) as the core of my plan. I chose reading as the core skill, because I wanted to work from what I perceived to be the students' strength. I thought that if they could do something they were better at (reading), they would have more confidence and willingness to persevere, even though the text was demanding. However, I was too optimistic about their reading ability and incidentally, also wrong in thinking that they would see the usefulness of being able to read and write medical reports in the future. The readings proved so difficult that students' comprehension was sadly low, even when they were faithful to use their dictionaries and do out-of-class preparation. More class time should have been devoted to detailed study of those journal articles in order to do them justice and make it a satisfying study. Without full understanding, the students could not feel the interesting point of synoptic or experimental research reports. To make matters worse, there was not adequate time, or fundamental knowledge about medicine on the students' part, for writing practice of frequent expressions and forms that appear in such research reports. Using that book in a full-year course would have made a big difference, but considering the students' background and knowledge level as freshmen or sophomores, it would be best to do such a study later or in a post-graduate course. It had been a case of poor judgment on my part. Everytime I worked in "other-skill" activities, I felt harried and somehow shortchanging the readings. After all, being a jack-of-all-trades, but master of none is not a very satisfying goal. The success of such an approach strongly rests on the condition that most of the activities are not extremely detailed or painstaking. The danger in this approach in a technical English program quickly appears in the form of not having enough time to 1) read and discuss difficult texts thoroughly, 2) follow up by really checking listening comprehension or homework 3) offer useful and related background information while doing activities like dictation, writing case histories, etc. It is very easy to arrive at a point of feeling that everything is hurried, watered down, disjointed, and just being done for the sake of being able to say that the class is "integrated". A couple years later when I changed the textbook to International Medical Communication in English (John Christopher Maher, 1990), the all-skills approach went much smoother because that book contains almost no readings at all. In fact it is more of a reference book of medically related terms, expressions, diagnostic questions, equipment, etc. This gave me the freedom to hand pick readings from periodicals and newspapers, as well as develop my own

conversational, listening, and writing exercises, but the work load and number of copies that had to be made each week were overwhelming. In addition, a few students complained that they wanted a text that would allow them a more systematic study of the body and its systems. I could not argue with that request, so the next year I adopted English for Medical Students (Kamiyama et al.. 1994). It integrates at least two skills reasonably well (though the doctor-patient conversations seem a touch unnatural and truncated at times) and is certainly adequate for a beginning study of body systems. The chapter readings in that book are moderately difficult but only one to two pages in length, so it is possible to explain the most troublesome passages and still have time to supplement the text with a layer of more basic vocabulary. Students seemed to welcome some added conversational vocabulary that would correspond to the technical terms. In fact, it was necessary to supplement with such everyday language in order to make the listening and speaking segments more authentic and dynamic.

Integrating for the sake of variety was a conscious thought, but at the onset the teacher's real conviction seemed to be more like "Most may never speak or listen to English much, but surely it will be an advantage if they can participate in international research by reading and submitting medical papers in English occasionally." Somehow I was focusing on what I knew to be their existing strengths. My rationale for doing so was not well supported, I must admit. Nevertheless, believing that reading especially would benefit the greatest number of students was the core assumption guiding the course design for the first two years. Needless to say, only a few token speaking and listening activities were incorporated during that period. This was one part of the course philosophy which changed greatly by the fourth time the course was taught. By that time, reading, speaking and listening were given equal emphasis. I deliberately underweighted writing exercises, because our general education program includes a separate course for essay writing which is quite intensive and detailed. On the other hand, there are fewer opportunities for all of the medical and nursing students to listen to a native English speaker and practice speaking.

(Relating specifically to Question 7 in the Abstract)

Activities, teaching methods, and testing procedures changed drastically, even after teaching the course two times. In short, the focus gradually shifted more and more toward listening and speaking skills. There were only about two to three assigned pages of textbook reading per week, and only one writing project which involved making an abstract of 150 words for a medical journal article of my choosing.

Listening and speaking skills were taught in tandem as much as possible. For example, I rediscovered new uses for dictation (for pretests and weekly classroom activities). Dictation, especially in the form of doctor-patient questions, diagnosing and counselling language, and patients' complaints, seemed to hold students interest and gave enough context to make new vocabulary memorable. A few examples (Fujieda, Tamamaki, and Mann, 1998) that make good dictation items follow:

a. (*greeting/opening remark*) (Parentheses indicate words easily replaced by others)
(Brackets [ ] indicate elements which are easily omittable)
Good morning, Mr. Peters. I hear you're having some trouble (breathing).
b. (*probing for information*)
What do you mean by [saying you have] ("a bad stomach")?
c. (*giving directions*)
Please, slip off your clothes down to the waist.
d. and **e.** (*forms comparing "trouble + -ing" and "trouble with your (noun)"*)
Are you having any trouble (swallowing)?
Are you having any trouble with (diarrhea) (your throat)?
f. (*teaching simplified forms*) (the above forms are shortened extremely to simulate natural conversational simplicity)
[Having] any trouble (sleeping)?
[Any] trouble with your (bowels)?
g. (*comments for counselling*)
Your healing depends on this (difficult therapy).
h. (*patient's complaints*)
These pills make me so (dizzy).
i. (*diagnosing language*)
It appears that you have some polyps in your large intestine.
j. (*sickroom care*)
Would you like me to (water your plants)?

The kind of language that can be used in a dictation knows no limit. It is even good for short patient case reports of about one paragraph: For example, "The patient, a 34-year-old Caucasian female, presented on Oct. 29 at 2:00 p.m. complaining of intolerable migraines, occuring unilaterally, behind and above the left eye..." Forms for such reports

can be found in a variety of textbook sources, and they usually include a description of the patient, the major complaint, examination findings, test results, recommended treatment and medication, patient prognosis, and follow-up remarks.

A brief scanning of the a-j items above will also make it evident that such an exercise can easily be incorporated into a full length dialogue or other activities that are even more highly interactive. Dictation can also be used as a "cold" exercise before students begin a new chapter or word list (a sort of pretest and previewing), but I would quickly add that it should not be graded and needs to be followed up immediately by discussion and checking of each item; that is, the teacher should display each dictated item and offer correct spelling and added information while the words are fresh in the students' minds. On a more regular basis, dictation seems a better exercise if it follows some preliminary study of new vocabulary and expressions. Here again, just dictation will not be so interesting or active unless it is followed up by a reinforcing exercise, and what could be more natural than incorporating the dictated items into a conversation, say, between a doctor and patient or two doctors. When I am dictating new material for the first time, I repeat each item three times. First at nearly natural speed, once at an obviously slower speed, and lastly again at natural speed. Then later, before I ask students to practice these items which have been incorporated in a dialogue, I always make it a practice to do repeat-after-me exercises (or "chants" or shadowing) for pronunciation of difficult medical items as well as more common, troublesome things like the "er" sound in *her, shirt, church*, etc. I believe time spent on pronunciation is never a waste of time. After all, there is nothing sadder than a student who works hard, achieves almost perfect grammar, really tries to communicate, but cannot be understood because of distorted pronunciation. It goes without saying that too much of any kind of practice can potentially become boring, so it is the teacher's responsibility to plan for variety.

A type of dictation can also be used as a kind of paper "speaking" test. Taking different parts from dialogues that students have actually practiced or even memorized in the class, the teacher dictates single questions or comments to which the students must quickly write appropriate responses. The idea is that if they can write a suitable response, the possibility of them being able to utter a correct retort is also high. It is one step better than a dialogue cloze reading test, because it also incorporates listening. Ideally, if class size is smaller, of course it would be best to actually include a real "speak test" in which you engage the student in a specific role and topic. As one can imagine, there are so many medical situations, in and out of the hospital, that it is easy to do simulations and role playing if class size and time permit.

Video is proving to be a very stimulating means of teaching medical language. One of my colleagues has made very effective use of the movies "The Doctor" starring William Hurt and "Lorenzo's Oil" starring Susan Sarandon (both with medical themes) for listening and reading. I myself am currently using the American television series "E.R." (Emergency Room) for a voluntary class for students wanting to study more specialized medical English. Even a small segment of each program can elicit many questions and discussion. After adequate explanation and prompting, most students can achieve near 100% comprehension upon the third viewing of a segment. When asking review type questions about previously watched programs, I find that students' retention rate of medical vocabulary and expressions is high, and the fact that they can use the language for speaking makes it all the more impressive.

TPR (Total Physical Response) is a perfect method for preparing would-be-doctors and nurses to give directions to their patients. Basic notions like *slip off your..., grab, bend, straighten, make a fist, raise, drop,* etc. can be learned excellently by listening and doing and then later by giving the directions verbally to one another or to the teacher.

Making hand-drawn illustrations of things which are hard to visualize (for example, the entire alimentary tract) proves useful for vocabulary retention. If students make such an image with numbers corresponding to all the pertinent parts of the drawing, they can practice together and check each other on memory of all parts of the imaging. In the course of doing so, they are also getting speaking and pronunciation practice.

My final tests for the course evolved to include at least 15 points of dictation. Usually I used doctor-patient questions which would be used during various kinds of physical examinations. One point was given for each question or statement: Half a point for grammatical correctness and function words and the other half-point for targeted content words. Doing this also gave me a basis for comparing dictation done as pretests or preliminary exercises with the final results to help me get a better idea of student progress. It also alerted me to terms and concepts that were extremely difficult and would need more attention the next time around.

I always taught the medical English course to 100 students. They were divided into two sections of 50 students each. One section met during the first class period of the day and the other section during the second period. Unfortunately, the second class always seemed to have the advantage of learning more. The later class always scored slightly higher on midterms and finals. Besides, they were more active in almost all activities. Part of this might have been due to the time of day. First period classes contain more sleepyheads, especially

on dark winter mornings. But I am sure that the second class benefitted from the fact that I had already tried the material with the earlier class. That undoubtedly made me more confident and able to know how to better facilitate classroom exercises.

Concluding Remarks

After even the first year of teaching a Medical English course, I became more and more convinced that focusing first and foremost on the most common medical language "that everybody uses" would prove more interesting and useable to a greater number of students. Furthermore, incorporating this language into listening and speaking activities was paramount, because they would have more opportunities to improve reading and writing skills in other classes. Collaborating with two other English teachers at FMU, it has been possible to produce our own foundational medical English textbook which will serve as a standard and reference for students in their first two years of general education courses. The book, entitled Medical Terms and Expressions Everybody Uses (Fujieda et al., 1998) was constructed bilingually (English and Japanese) with indexes in both languages to make it more user friendly. It will be interesting to see what kind of learning will result when this book is used as a text and reference in a variety of classes, involving all four English skills.

Last but not least, teachers should be encouraged to include areas of their own special interest. Some may have special knowledge of world health problems, or environmentally related health issues, or as it was in my case, holistic medicine. After all, if the teacher is enthused, there is a better chance of the students' interest being deeper. It goes without saying that preparing for ESP classes will be just as demanding for the teacher as for the students, but experience bears out that it is definitely possible to stay several steps ahead of the students. Teachers might also take heart from the fact that this is a time when students will be forming career decisions based on their impressions of various aspects of medicine. It is a chance to have a very positive influence in their lives and to enrich their futures by helping them to feel at ease in the international arena of medicine through English.

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